CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

Division of Risk Management
Workers' Compensation Section

WORKERS' COMPENSATION EMPLOYEE'S NOTICE OF INJURY (*COMPLETE ALL ITEMS*)

EMPLOYEE'S NAME (last) (first) (initial)

EMPLOYEE'S ADDRESS (no.) (street)

(city) (state) (zip) TELEPHONE: Home ____ Work ____

SOCIAL SECURITY NO. | DATE OF BIRTH (mo.) (day) (year) | SEX: ☐ Female ☐ Male

MARITAL STATUS: ☐ Married ☐ Single ☐ Widow(er) ☐ Divorced | NUMBER OF DEPENDENT CHILDREN UNDER 18 AT DATE OF INJURY

DATE OF INJURY OR ILLNESS (mo.) (day) (year) | TIME A.M. P.M. | LAST DAY WORKED

NAME OF AGENCY | ADDRESS OF AGENCY

REPORTED TO SUPERVISOR? ☐ Yes ☐ No | NAME OF SUPERVISOR | DATE & TIME REPORTED a.m. p.m. (mo.) (day) (year)

IF NOT REPORTED ON DATE OF INCIDENT, EXPLAIN

HAVE YOU SOUGHT MEDICAL ATTENTION ☐ Yes ☐ No | NAME, ADDRESS, PHONE NO. OF DOCTOR

ANY SICK, VACATION OR PERSONAL DAYS USED FOR THIS INJURY? ☐ Yes ☐ No | NUMBER AND TYPE

HAS ANY INSURANCE COMPANY PAID FOR TREATMENT AS A RESULT OF THIS INJURY? ☐ Yes ☐ No | NAME AND POLICY NO.

WHAT DUTY WERE YOU PERFORMING AT TIME OF INJURY? (BE SPECIFIC)

PLACE WHERE INJURY OCCURRED (BE SPECIFIC)

DETAIL HOW INJURY OCCURRED (USE REVERSE SIDE IF NECESSARY)

DID A NEGLIGENT THIRD PARTY CAUSE OR CONTRIBUTE TO ACCIDENT? ☐ Yes ☐ No

IF YES, EXPLAIN AND PROVIDE, ADDRESS, AND PHONE # OF NEGLIGENT PARTY: (USE REVERSE SIDE IF NECESSARY)

DESCRIBE INJURY (INDICATE PART(S) OF BODY AFFECTED)

ANY WITNESS(ES) TO INJURY ☐ Yes ☐ No | IF YES, NAME(S)

HAVE YOU SUBMITTED ANY CLAIMS FOR INJURY / ILLNESS IN THE PAST 10 YEARS? (IF YES, IDENTIFY EACH ON REVERSE SIDE) ☐ Yes ☐ No

DATE THIS FORM COMPLETED ____ (mo.) (day) (year) | SIGNATURE OF INJURED EMPLOYEE ____

IF INJURED EMPLOYEE UNABLE TO SIGN ABOVE, SIGNATURE OF INDIVIDUAL COMPLETING THIS FORM

REVERSE SIDE MUST BE COMPLETED, IF APPLICABLE BEFORE SUBMISSION TO CMS

ADDITIONAL DETAILS HOW INJURY OCCURRED

PREVIOUS INJURIES OR ILLNESSES

DATE(S) OF INJURY / ILLNESS	DESCRIBE INJURY / ILLNESS	WAS THIS WORK. COMP. YES OR NO	NAME AND ADDRESS OF DOCTOR	IF YES, AMOUNT OF SETTLEMENT

ADDITIONAL DETAILS CONCERNING THIRD PARTY NEGLIGENCE